DWS-OSD 20M
Rev. 08/2007

State of Utah
Department of Workforce Services

MENTAL STATUS & TREATMENT/PROGRESS REPORT

Date Received

PID#: _____

TO THE MENTAL HEALTH CARE PROVIDER:

This person ☐ is applying for Medicaid Disability Benefits, or
☐ is currently receiving Benefits and his/her case is up for review.

In order for us to evaluate this person's qualifications to receive benefits, we need medical evidence as to the nature of his/her condition, and the severity of the associated impairment.

This form should be completed by the TREATING PHYSICIAN or therapist.
Please complete the form based on your knowledge of this individual, using existing treatment and progress records and results of previous evaluations, as well as current observations.

A narrative report, covering the following points, may be substituted instead of this form.
NOTE: A history (from existing records) of treatment and progress, as well as a description of demonstrable signs and observations, is far more useful than a subjective report from the client.

DO NOT give the report to the client. **Return the completed report to the worker.**

Worker's Name:		Worker's Address:			
Title:		Department:		Phone#:	
Client's Name:		SS#:		Client ID#:	

TO THE WORKER:

This form should be sent to the person who treats the client for his mental problems.

Please **include a pre-addressed return envelope** that the provider can use to return the completed form/report in. Completed form/report should not be given to the client. Include your name, address, and telephone number above so the provider can contact you if necessary.

Include a completed form **MI 706 Request for Medical Information** with the form 20M. The doctor will use the MI 706 for payment purposes. If the doctor requests additional evaluations or testing before completing the form 20M, refer him/her to the instructions and phone number on the back of the MI 706.

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1. Patient's Name: _____ SSN: _____ Client ID#: _____

2. Name of Reporting Physician (Printed/Typed): _____ Title: _____ Phone#: _____

3. Patient First Examined: _____ Date of Last Exam: _____ Frequency of Visits: _____

4. **GENERAL OBSERVATIONS**: Does the patient require assistance to keep his/her appointments? In what way and by whom? Please describe posture, gait, mannerisms, and general appearance.

5. **PRESENT ILLNESS:** What are the patient's complaints and symptoms? How and when did they begin? Is this a new condition, or an exacerbation of a chronic condition?

6. **PAST HISTORY OF TREATMENT:** If patient has been hospitalized, please indicate dates, location, and course of treatment. Also describe any outpatient treatment, including Day treatment, Residential Treatment facilities, etc.

7. **FAMILY, SOCIAL, AND ENVIRONMENTAL HISTORY:** Briefly discuss the following areas, if relevant; family, education, marriage, divorce, work, sickness, alcohol, drug abuse, prison, etc.

8A. **ATTITUDE AND BEHAVIOR:** Please describe the patient's general attitude, e.g., pleasant, hostile, relaxed, fearful, etc., and any examples of noteworthy behaviors, e.g., tearfulness, motor activity, explosive behavior, etc.

8B. **INTELLECTUAL FUNCTIONING/SENSORIUM:** Please describe and provide specific examples of orientation, memory, concentration, signs of organicity, judgement, etc. Include copies of any test results available to you.

8C. **AFFECTIVE STATUS:** Please present any evidence of anxiety, depression, phobias, psychophysiological disturbances, conversion symptomatology, suicidal/homicidal ideation, etc. Describe any physical manifestations, e.g. tremors, weight change, insomnia, etc.

8D. **REALITY CONTACT:** Does the patient present delusions, hallucinations, paranoid ideation, confusion, mood swings, emotional liability, emotional withdrawal/seclusiveness, bizarre/unusual behavior, etc? Please describe in detail.

9A. **PRESENT DAILY ACTIVITIES:** Discuss the degree of assistance or direction needed to properly care for personal affairs, do shopping, work, drive a car, etc. In what ways, if any, have the patient's daily activities changed as a result of the patient's mental condition?

9B. **PRESENT INTERESTS:** Describe the patient's interests and use of free time such as family, home, friends, business, politics, sports, hobbies, projects, etc. In what ways, if any, have these changed as a result of the patient's mental condition?

9C. **ABILITY TO RELATE:** Describe how patient gets along with and communicates with family members, neighbors, friends, fellow employees, supervisors, etc. In what way has this changed as a result of the patient's condition?

9D. **PERSONAL HABITS:** Describe the patient's grooming, clothing, hygiene, etc. In what ways, if any, have personal habits changed as a result of the patient's mental condition?

10. **MEDICATION:** DOSAGE AND FREQUENCY: _____

11.
DIAGNOSIS: _____

12. **PROGNOSIS:** Can the patient's condition be expected to improve? If so, when do you consider significant change likely to occur?

13. **COMPETENCY:** Is patient competent to manage funds on his/her behalf? _____

14. **ADDITIONAL COMMENTS:** Attach additional pages, if necessary. _____

15. _____ _____

Signature of Physician | Date

NOTE: If completed and signed by other than an MD/PhD, an LCSW for instance, the form needs to be cosigned by an MD or PhD. If copies of previous reports (signed by an MD or PhD) are included, this form would not need to be cosigned.

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